

**EFGARTIGIMOD ALFA-FCAB (VYVGART®) AND****EFGARTIGIMOD ALFA AND HYALURONIDASE-QVFC (VYVGART® HYTRULO) PRESCRIBER ORDER FORM**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Height: \_\_\_\_\_

 inches  cm

Weight: \_\_\_\_\_

 lbs  kg**Clinical Information**

Primary Diagnosis Description: \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_

**Prescription** **VYVGART® (efgartigimod alfa-fcab) 400mg in 20mL**

- Infuse 10 mg/kg IV over one (1) hour every week x 4 weeks for 1 treatment cycle. Max 1200mg dose for patients >120kg.
- Using a 50 mL 0.9% Sodium Chloride IV bag, flush IV tubing with 10 to 20 mL after each infusion.
- Infuse via 0.2 micron in-line filter
- Dispense quantity sufficient of 400mg single dose vials for each dose. Round calculated dose to nearest 20mg increment.
- Withdraw calculated dose from vial and discard any unused vial contents.

Repeat cycle after \_\_\_\_\_ days from the first dose of the previous treatment cycle. Refill x 1 year.

 **VYVGART® HYTRULO (efgartigimod alfa and hyaluronidase-qvfc) 1008mg/11,200 units in 5.6mL Single Dose Vial**

- Dispense 1008 mg/11,200 units
- Infuse **Subcutaneously** over 30-90 seconds.
- Single Dose Vial to be administered by a healthcare professional only.
- Administer using a winged 25G 12in tubing (maximum priming volume of 0.4 mL)

 **VYVGART® HYTRULO (efgartigimod alfa and hyaluronidase-qvfc) 1000mg/10,000 units in 5 mL PreFilled Syringe**

- Dispense 1000 mg/10,000 units
- Infuse **Subcutaneously** over 20-30 seconds.
- Prefilled syringe may be administered by patients and/or caregivers after proper instruction in subcutaneous injection technique

 **gMG: Infuse weekly x4 weeks for 1 treatment cycle. Repeat cycle after \_\_\_\_\_ days from the first dose of the previous treatment cycle. Refill x 1 year.** **CIDP: Infuse weekly. Refill x 1 year.** Additional Vyvgart orders: \_\_\_\_\_**Ancillary Orders****Anaphylaxis Kit**

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.

**Pre-Medication Orders** \_\_\_\_\_**IV Flush Orders**

- Peripheral:** 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- Implanted Port:** 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed. If peripheral IV, RN to insert. If port, RN to access. Refill above ancillary orders as directed x 1 year.

*I certify that the use of the indicated treatment is medically necessary and that I will be supervising the patient's treatment.*

Prescriber Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Prescriber Information**

Prescriber Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Address: \_\_\_\_\_

NPI: \_\_\_\_\_

City, State: \_\_\_\_\_

Zip: \_\_\_\_\_

Office Contact: \_\_\_\_\_

**Fax completed form, insurance information, and clinical documentation to:**

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